



DEPARTMENT OF THE ARMY
HEADQUARTERS, PACIFIC REGIONAL MEDICAL COMMAND
1 JARRETT WHITE ROAD
TRIPLER AMC, HAWAII 96859-5000

REPLY TO
ATTENTION OF

MCHK-PST
Tri-Service Addiction Recovery Facility (TRISARF)
1 Jarrett White Rd.
Tripler Army Medical Center, HI 96859-5000

Date: _____

MEMORANDUM FOR _____

SUBJECT: **Memorandum of Agreement with Command** for _____

1. The Service Member was evaluated for a chemical addictions rehabilitation program and has been assessed to be appropriate for Tri-Service Addictions Recovery Facility (TRISARF), Tripler Army Medical Center (TAMC). Arrangements have been made for this Service Member to begin this intensive addictions rehabilitation program on _____.

2. This Service Member will be required to be present on 4th floor B wing, TRISARF, wearing the prescribed service branch working uniform at 0800 hours on the above start date. The program is 5 to 6 weeks duration.

3. The Service Member's spouse/significant other is strongly encouraged to participate in TRISARF's Family Program. They are invited to attend the orientation day and can meet with the Family Program Director to schedule individual and couples appointments. They are also invited to attend the commencement day for their family member.

4. REQUIREMENTS FOR COMMAND SUPPORT.

a. An essential component of recovery and continued sobriety is a healthy living environment. If the Service Member lives in the barracks every effort should be made to place this Service Member in a room with **non-drinking roommates**.

b. Self-help meetings (Alcoholic's Anonymous, Narcotic's Anonymous, etc.) are an integral part of TRISARF's treatment program. Patients are required to attend a **minimum of 3 self-help meetings per week**. If the Service Member is unable to do so, review of the appropriateness for treatment will be conducted by the clinical team. Therefore, Service Members **must be excused** from any duty obligations that could interfere with this vital treatment requirement.

(Approving Official initial here: _____)

c. The Service Member and command share the responsibility of ensuring the Service Member attends the entire TRISARF treatment day. The command must refrain from scheduling activities such as non-emergent appointments, training activities, formation, and PT, during treatment hours. If the Service Member must stand duty the night before a TRISARF treatment day they must be allowed to get to sleep no later than midnight.

(Approving Official initial here: _____)

Last Name: _____ First Name: _____
SSN: _____ DOB: _____

d. Attending the entire program is critical. Service Members will not be allowed to take leave during their treatment at TRISARF. All legal actions, including restriction and extra duty, MUST BE COMPLETED PRIOR TO OR SUSPENDED UNTIL AFTER COMPLETION OF TREATMENT. Service Members will not be enrolled in the program while on restriction or extra duty. If the Service Member is placed on restriction or extra duty while enrolled in TRISARF their treatment will be suspended until they complete their NJP.

(Approving Official initial here: _____)

5. REQUIREMENTS OF SERVICE MEMBER.

a. The Service Member must comply with all of TRISARF's rules and regulations. Failure to do so will be reported to the Service Member's command and will be discussed by the treatment team to determine continued treatment at TRISARF.

b. The Service Member must attend the entire TRISARF treatment day. Command will be notified of an unauthorized absence.

c. The Service Member will be required to wear their working uniform while in treatment. Every Wednesday and Friday patients are required to participate in an exercise activity based on their ability. Service Members are to wear their **PT shorts, T-shirts, socks and sneakers. A towel is also needed. If the Service Member is on profile or limited duty a copy of the profile or limited duty chit must be presented to TRISARF staff.**

6. TRISARF's program is an intensive addictions treatment program. It is based on individual need with a varying length of stay. TRISARF will provide the command with an approximate release date, once identified.

7. For further information, please contact **ADD SARP, ADAPT, ASAP, SACC INFORMATION HERE**

Case Manager Name _____

Signature _____

I, as the Approving Official, have read the above requirements and support _____ to fully participate in TRISARF's intensive addictions treatment program based on these written requirements.

Signature _____

Title _____

Telephone Number _____

Revised: 04November2010

Last Name: _____ First Name: _____
SSN: _____ DOB _____